PUBLIC HEALTH SERVICES DISTRICT
COCONINO COUNTY

Barbara Worgess
Chief Health Officer

COCONINO COUNTY
HEALTH DEPARTMENT

ENVIRONMENTAL HEALTH

Medical Record of Hepatits B Vaccination Status

Name of Operator: _____

1. Attach medical record or vaccination record documenting vaccination series for HBV.

2. Hepatitis B vaccination dates
   1st _____ Provider _____
   2nd _____ Provider _____
   3rd _____ Provider _____

3. Operator choose to WAIVE Hepatitis B vaccination series.
   This section is only to be filled out if vaccination is being declined. The staff at Coconino County cannot witness for the applicant.

   I understand that due to my occupational exposure to blood or other potentailly infectious materials, I may be at risk of acquiring Hepatits B Virus (HBV) infection.
   I wish to decline the opportunity to receive this vaccination. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B Virus. If in the future I continue to be occupationally exposed to blood or other potentially infectious materials, I may choose to receive the Hepatitis B virus vaccination.

   Signature: _____

   Print Name: _____

   Date: _____

A WITNESS MUST SIGN IF DECLINING HEPATITIS B VACCINATION:

Witness Signature: _____

Witness Printed Name: _____

Date: _____

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